

1 M

**MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

05937

**CERTIFICATE OF DEATH**

05934

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		Somerset MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Crisfield		1 Day		Crisfield, Maryland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
McCready Memorial Hospital		Traillor 10, Landon Point		19-1	
77					
3. NAME OF DECEASED (Type or print)		First Infant	Middle Female	Last Brock	4. DATE OF DEATH Month Apr / Day 17 Year 1966
5. SEX		6. COLOR OR RACE Female White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH April 16, 1966	9. AGE (In years last birthday) No yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Crisfield, Maryland	
None		None		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
Robert E. Brock		Martha Baine			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address	
No None		None		Robert E. Brock, Same as 2. abcd	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>abortion -</i>					
7620 Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. DUE TO (b) <i>Caesarean Section, mother because</i>					
DUE TO (c) <i>Severe vag. infestation -</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on 4/17/66 19_____, and that death occurred at 5:20 P.M., from the causes and on the date stated above.					
22a. SIGNATURE <i>S. M. Peyton</i>					
22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type)		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS Crisfield, Maryland	
S. M. Peyton, M.D.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIUM	
Burial		April 18, 1966		St. Peter's Cemetery	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR DATE APR 20 1966	
Bradshaw & Sons, Crisfield, Maryland				25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>	



1  
M

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

**05938****CERTIFICATE OF DEATH****05935**

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH		Somerset		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)							
a. COUNTY						a. STATE Maryland b. COUNTY Somerset							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)							
Crisfield						Marion Station							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						d. STREET ADDRESS							
McCready Memorial Hospital						R. F. D.							
e. IS RESIDENCE ON A FARM?													
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year					
Male		Lake		Conner	Apr.	30	19	66					
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		10. IF UNDER 1 YEAR		11. IF UNDER 24 HRS.	
		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Nov. 1, 1896		69 yrs.		Months		Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?							
Foreman		County Roads Comm.		Marion Station, Md.		U.S.A.							
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME											
Joseph W. Conner		Drucilla Corbin											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address							
No		220-32-1598		Mrs. Lucille Conner, same as 2, a.b.c.d.									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Arterio Sclerotic heart disease, Heart block, Cardiogenic shock											
4200 Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.		DUE TO (b) General arterio sclerosis & chronic appendicitis											
		DUE TO (c) Myocarditis											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		General arterio sclerosis											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
		—											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
19													
21. I certify that (I) (this hospital) attended the deceased from 1-20, 1966 to 4-30, 1966, that (I) (we) last saw the deceased alive on 4/30/66 19_____, and that death occurred at Marion Station, Md., from the causes and on the date stated above.													
22a. SIGNATURE						22b. DATE SIGNED							
G. C. Coulbourn, M.D.													
22c. PHYSICIAN'S NAME (Type)				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS							
G. C. Coulbourn, M.D.						Crisfield, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION (City, town or county) (State)							
Burial		May 3, 1966		St. Paul's Cemetery		Marion Station, Md.							
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Bradshaw & Sons — Crisfield, Md.				MAY 5 1966		Charles Judge							



1 M

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

05939

**CERTIFICATE OF DEATH**

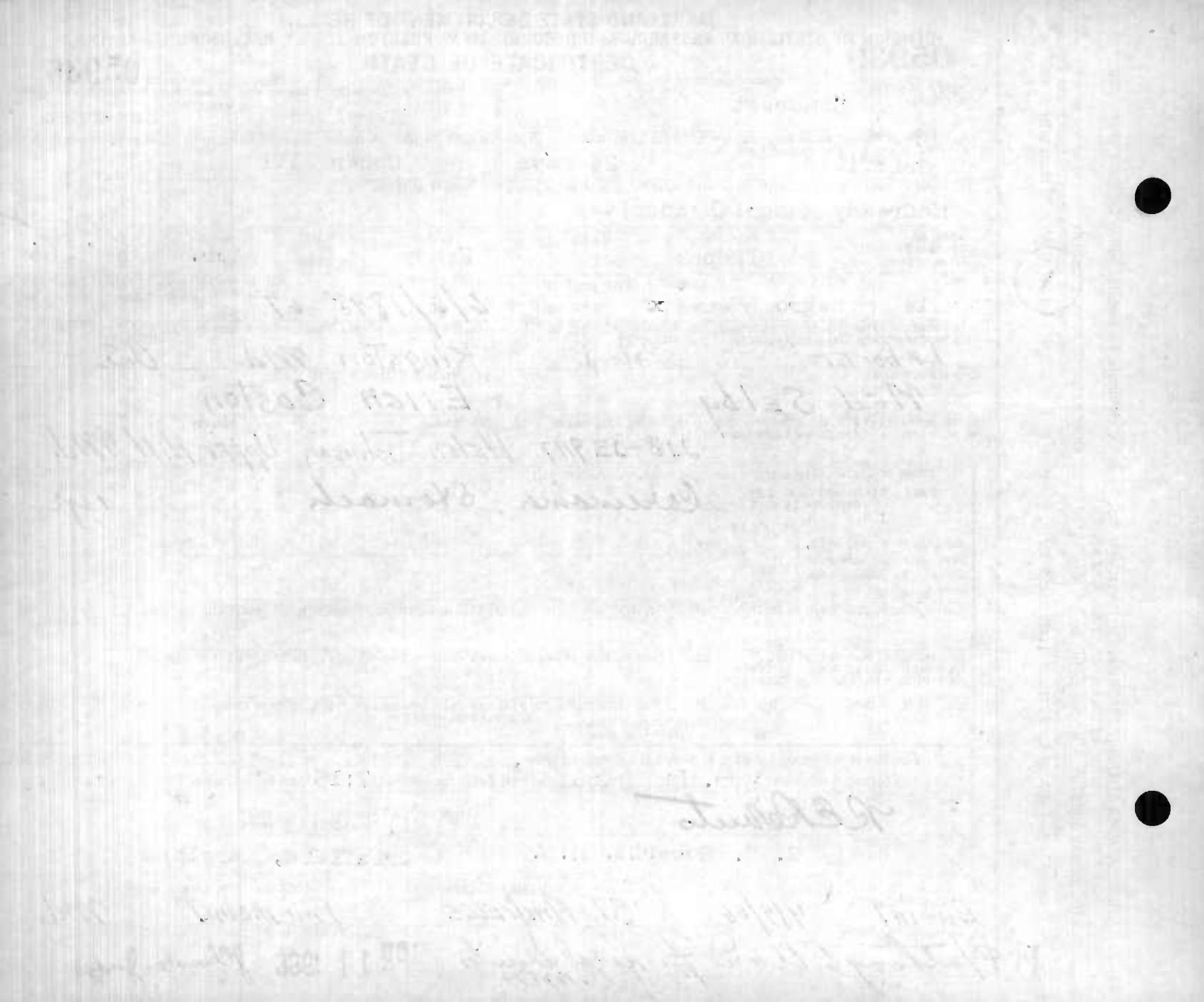
05936

1. PLACE OF DEATH a. COUNTY		Somerset		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		Crisfield		c. LENGTH OF STAY IN 1b 25 Days		a. STATE Maryland			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		McCreaddy Memorial Hospital		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Upper Hill		b. COUNTY Somerset			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)		First Blanche	Middle 	Last Handy	4. DATE OF DEATH Apr. 4 1966	Month Apr.	Day 4	Year 1966	
5. SEX		6. COLOR OR RACE Female Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/6/1898	9. AGE (In years last birthday) 67 yrs.	IF UNDER 1 YEAR Months 	IF UNDER 24 HRS. Days 	Hours 	Min. 
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Laborer Seafood		11. BIRTHPLACE (County & State, or foreign country) Kingston Md.		12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Ned Selby		14. MOTHER'S MAIDEN NAME Eileen Coston		Address Helen Johnson Upper Hill Md.					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 218-33-9117		17. INFORMANT		INTERVAL BETWEEN ONSET AND DEATH 142			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 151X		Coronary Sxomach							
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) _____	(c) _____						
DUE TO									
DUE TO									
DUE TO									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on Apr. 1 1966, and that death occurred at 7:15 PM from the causes and on the date stated above.						22b. DATE SIGNED			
22a. SIGNATURE R.E. Roberts				M.D. ATTENDING PHYS. <input type="checkbox"/> M.D. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
22c. PHYSICIAN'S NAME (Type) R. E. Roberts, M.D.		22d. ADDRESS Crisfield, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/9/66		23c. NAME OF CEMETERY OR CREMATORIAL ST. Andrews		23d. LOCATION (City, town or county) Fairmount			
(State)									
24. FUNERAL DIRECTOR Anthony G. Ward Funeral Director Crisfield MD.		ADDRESS		25a. REC'D BY REGISTRAR 1966		25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05940

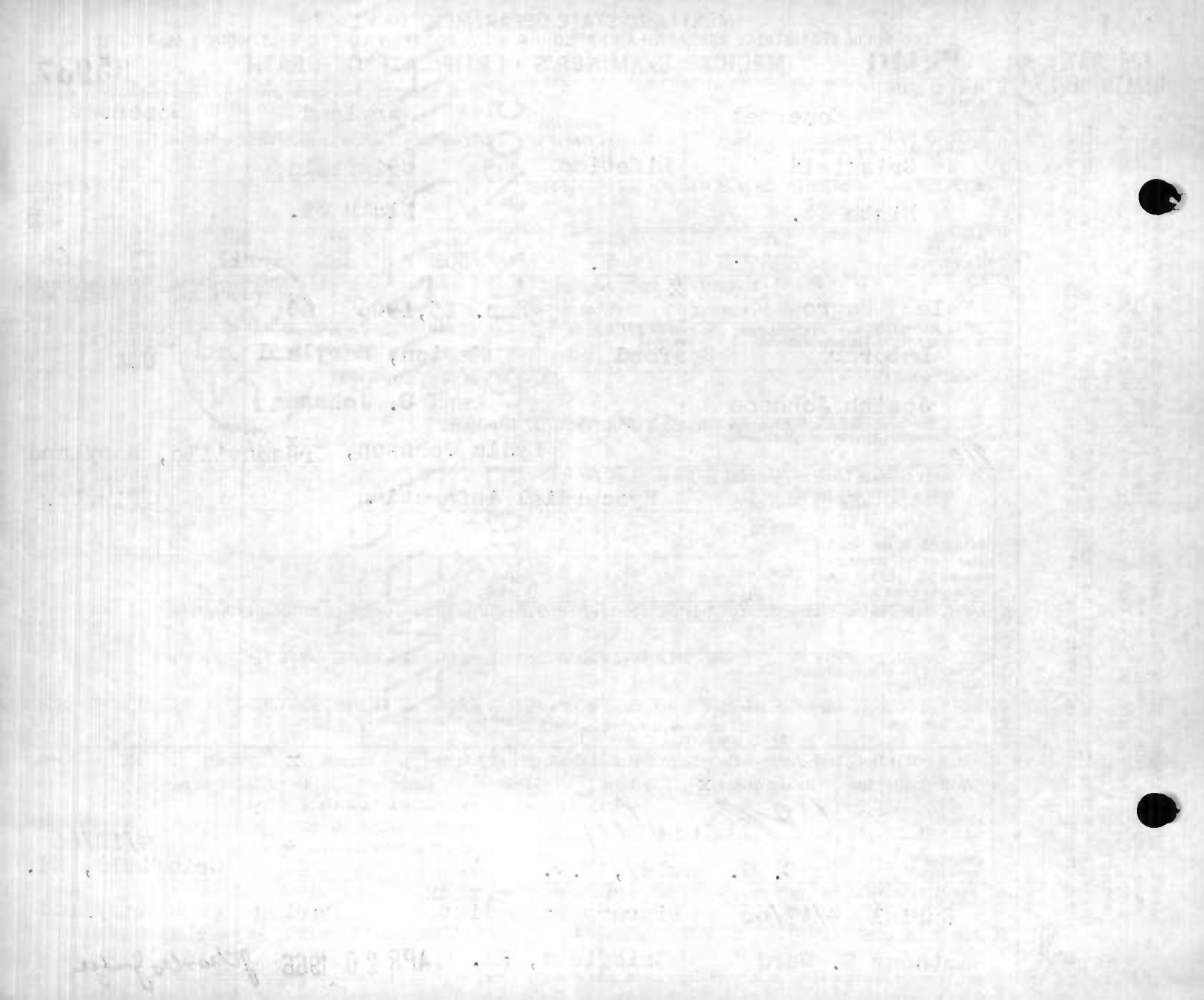
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05937

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute one certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1, and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1		6		MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
FOR STATE HEALTH DEPT.		M		2. PLACE OF DEATH a. COUNTY		Somerset		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)		a. STATE Maryland		b. COUNTY Somerset			
		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Crisfield		c. LENGTH OF STAY IN 1b		Lifetime		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Crisfield		19.1			
		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Ninth St.		d. STREET ADDRESS		Ninth St.		e. IS RESIDENCE ON A FARM?		YES <input type="checkbox"/>		NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH		Month		Day		Year			
WEBSTER		T.		JOHNSON		JOHNSON		April		13		19		66			
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.					
Male		Negro		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Mar. 15, 1906		60 yrs.		Months		Days		Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?					
Laborer				Seafood				Marion, Maryland				USA					
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME				Address									
Josiah Johnson				Anna B. Johnson				Lydia Johnson, Box 67, Grasonville, Maryland									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT				INTERVAL BETWEEN ONSET AND DEATH Minutes					
No								Lydia Johnson, Box 67, Grasonville, Maryland									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]																	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction																	
4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)																	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)																	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
19																	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and In my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE <i>C. G. Rawley</i>																	
EXAMINER'S NAME (Type)				C. G. Rawley, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22. DATE SIGNED 4/18/66					
								M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>									
								DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
23a. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR Crematory Burial 4/17/66 Library Methodist Marion Maryland																	
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE APR 20 1966 <i>Charles Judge</i>					
Anthony E. Ward				Crisfield, Md.				D									
VR AISM (5 5M 1/65)																	



1  
FOR STATE  
HEALTH DEPT.

M

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05941

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05938

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)	
Somerset MARYLAND		a. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Rural-Westover	17 years	Rural-Westover	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ---		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First OLIVER Middle HERMAN Last KING		4. DATE OF DEATH April 8 1966	
5. SEX Male White 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH April 2, 1902 9. AGE (In years last birthday) 64 yrs.		10. IF UNDUE 1 YEAR Months Days Hours Min.	
WIOOWEO <input type="checkbox"/> DIVORCED			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		11. BIRTHPLACE (State or foreign country) Missouri	
10b. KIND OF BUSINESS OR INDUSTRY Farming		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Elmer King		14. MOTHER'S MAIDEN NAME Sarah Elizabeth Blank	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 279-22-6181 17. INFORMANT Mrs Genevieve King, Westover, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized lymphosarcoma		INTERVAL BETWEEN ONSET AND DEATH 2yrs	
2001 Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)			
DUE TO			
OUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Everett Sutter</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Everett Sutter MD		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED 4-9-66			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-10-1966 23c. NAME OF CEMETERY OR CREMATORIUM Holly Grove Mennonite	
24. FUNERAL DIRECTOR Robert H. Watson		23d. LOCATION (City, town or county) Somerset County, Md.	
ADDRESS		25a. REC'D BY REGISTRAR APR 11 1966 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
DATE			

56-31

NAME OF PLANT: THE FOUNTAIN FLOWERS

ADDRESS: 1000 N. 10TH ST., PHOENIX, ARIZ.

TELEPHONE: 2-1210

TYPE OF BUSINESS: RETAIL FLORIST

NUMBER OF EMPLOYEES: 10

WEEKLY SALES: \$10,000.00

ANNUAL SALES: \$520,000.00

ANNUAL PROFIT: \$100,000.00

ANNUAL EXPENSES: \$420,000.00

ANNUAL NET PROFIT: \$18,000.00

ANNUAL INVESTMENT: \$100,000.00

ANNUAL RETURN ON INVESTMENT: 18%

ANNUAL PAYBACK PERIOD: 5.56 YEARS

ANNUAL CASH FLOW: \$18,000.00

ANNUAL CASH FLOW PER EMPLOYEE: \$1,800.00

ANNUAL CASH FLOW PER OWNER: \$18,000.00

ANNUAL CASH FLOW PER SHAREHOLDER: \$18,000.00

OWNER'S SHARE

2001 11 05A 1001 00000001

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

M

05942

## CERTIFICATE OF DEATH

Reg. Dist. No. 115939

1. PLACE OF DEATH a. COUNTY <i>Somerset</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Marion</i>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Nation</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>None</i>		d. STREET ADDRESS d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>Senneria</i>	Middle <i>G.</i>	Last <i>Logan</i>
4. DATE OF DEATH	Month <i>April</i>	Day <i>11</i>	Year <i>1966</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 14, 1876</i>
9. AGE (In years last birthday) yrs. <i>89</i>	10. IF UNDER 1 YEAR Months <i>10</i>	11. IF UNDER 24 HRS. Days <i>28</i>	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Hopewell</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Alfred Miles</i>		14. MOTHER'S MAIDEN NAME <i>Sabre Johnson</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No.</i>		16. SOCIAL SECURITY NO. <i>23-14-7302</i>	
17. INFORMANT <i>Mrs. Hazel Croswell - Ft. 1 Box 361</i>		Address <i>Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute dilatation heart -</i> DUE TO <i>Myocarditis chronic -</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>Gen'l arterio sclerosis - Senility</i>			
INTERVAL BETWEEN ONSET AND DEATH <i>1 mo yrs - yrs</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>11/17/46</i> , 19 <i>66</i> , to <i>Apr. 7</i> , 19 <i>66</i> , that I last saw the deceased alive on <i>Apr. 7</i> , 19 <i>66</i> , and that death occurred at <i>6:30 M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>C. G. Rawley.</i>		ADDRESS (Street, city or town, state) <i>Crisfield, Maryland</i>	
PHYSICIAN'S NAME (Type) <i>C. G. Rawley, M.D.</i>		DATE SIGNED <i>4/12/66</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>April 14, 1966</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Wesley</i>		22d. LOCATION (City, town, or county) (State) <i>Marion Sta., Md. Som. Co.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Charles H. Ward Marion Sta., Md.</i>		ADDRESS 24a. REC'D. BY REGISTRAR DATE <i>APR 14 1966</i>	
		24b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director.

The registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF VIRGINIA  
CERTIFICATE OF DEATH

100

100

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** This certificate has been signed by the attending physician and completely filled in before being given to you. Then please remove carbon paper. Pages 1 and 2 should be deleted for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05943

## CERTIFICATE OF DEATH

Reg. Dist. No. 05941

1. PLACE OF DEATH a. COUNTY <b>Somerset</b>		MARYLAND		2. USUAL RESIDENCE [Where deceased lived. If institution: Residence before admission] a. STATE <b>Md.</b>		b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westover</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westover, Md., Rt. 1 #193</b>		d. STREET ADDRESS <b>19-1</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <b>Estella</b>	Middle <b></b>	Last <b>Maddox</b>	4. DATE OF DEATH Month <b>April</b>	Day <b>21</b>	Year <b>1966</b>
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 18, 1886</b>	9. AGE (In years last birthday) yrs. <b>79</b>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Westover Som.-Co.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Noah Collins</b>				14. MOTHER'S MAIDEN NAME <b>Nancy Ballard</b>		Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>None Ida Collins-Westover, Md. Rt. 1 #193</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>5021</b>		DUE TO <b>Ghronic Bronchitis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b></b>		DUE TO <b>Exposure to Col</b>					
(c) <b></b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Myocarditis &amp; Pericarditis</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b></b>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, form, factory, street, office bldg., etc.) <b></b>			
20f. (City or town) <b></b>				(County) <b></b>			
				(State) <b></b>			
21. I certify that I attended the deceased from <b>Feb 10, 1965</b> , to <b>Apr 121, 1966</b> , that I last saw the deceased alive on <b>Apr 1, 1965</b> , and that death occurred at <b>6-02</b> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b></b>		DATE SIGNED			
ACTUAL SIGNATURE <b>Elva G. Marion</b>		M.D.		<i>Princess Anne, Md.</i>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>APP. 24-66 St. James Cemetery</b>		22b. DATE THEREOF <b>Westover, Som.-Co., Md.</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b></b>		22d. LOCATION (City, town, or county) <b></b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles H. Hard-Marion Star, Md.</b>		ADDRESS <b></b>		24a. REC'D BY REGISTRAR <b></b>		24b. REGISTRAR'S SIGNATURE <b></b>	

WISCONSIN STATE INSURANCE DIVISION  
CERTIFICATE OF DEATH

1990

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

26

27

28

29

30

31

32

33

34

35

36

37

38

39

40

41

42

43

44

45

46

47

48

49

50

51

52

53

54

55

56

57

58

59

60

61

62

63

64

65

66

67

68

69

70

71

72

73

74

75

76

77

78

79

80

81

82

83

84

85

86

87

88

89

90

91

92

93

94

95

96

97

98

99

100

101

102

103

104

105

106

107

108

109

110

111

112

113

114

115

116

117

118

119

120

121

122

123

124

125

126

127

128

129

130

131

132

133

134

135

136

137

138

139

140

141

142

143

144

145

146

147

148

149

150

151

152

153

154

155

156

157

158

159

160

161

162

163

164

165

166

167

168

169

170

171

172

173

174

175

176

177

178

179

180

181

182

183

184

185

186

187

188

189

190

191

192

193

194

195

196

197

198

199

200

201

202

203

204

205

206

207

208

209

210

211

212

213

214

215

216

217

218

219

220

221

222

223

224

225

226

227

228

229

230

231

232

233

234

235

236

237

238

239

240

241

242

243

244

245

246

247

248

249

250

251

252

253

254

255

256

257

258

259

260

261

262

263

264

265

266

267

268

269

270

271

272

273

274

275

276

277

278

279

280

281

282

283

284

285

286

287

288

289

290

291

292

293

294

295

296

297

298

299

300

301

302

303

304

305

306

307

308

309

310

311

312

313

314

315

316

317

318

319

320

321

322

323

324

325

326

327

328

329

330

331

332

333

334

335

336

337

338

339

340

341

342

343

344

345

346

347

348

349

350

351

352

353

354

355

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
M

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
05944 05941

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY		Somerset MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE		Maryland					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		b. COUNTY		Somerset					
Crisfield		Lifetime		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Crisfield					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		Mariners Section		d. STREET ADDRESS		Mariners Section					
3. NAME OF DECEASED (Type or print)		First SADIE	Middle FONZY	Last OUTTEN	4. DATE OF DEATH	Month April	Day 12	Year 19 66			
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. UNDER 1 YEAR	11. UNDER 24 HRS				
Female		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Dec. 4, 1910	55 yrs.	Months	Days	Hours	Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
Housewife			At Home			Deal Island, Md.			U.S.A.		
13. FATHER'S NAME		Milbourne Elliott, Sr.			14. MOTHER'S MAIDEN NAME		Fannie Crockett				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address					
No				Maurice Outten, same as 2 a.b.c.d. above							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarct</i> INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>											
4201 Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
19											
21. I certify that (I) (this hospital) attended the deceased from <i>1964</i> , to <i>4/11</i> , 19 <i>66</i> that (I) (we) last saw the deceased alive on <i>4/11</i> 19 <i>66</i> and that death occurred at <i>6 AM</i> , from the causes and on the date stated above.											
22a. SIGNATURE <i>RE Roberts</i> 22b. DATE SIGNED <i>4/12/66</i>											
22c. PHYSICIAN'S NAME (Type)		Robert E. Roberts, M.D.		22d. ADDRESS		512 W. Main St.-Crisfield, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION (City, town or county)		(State)			
Burial		Apr. 15, 1966		Sunnyridge Memorial Park		Crisfield, Md.					
24. FUNERAL DIRECTOR		ADORESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Bradshaw & Sons--Crisfield, Md.				APR 20 1966		<i>Charles Judge</i>					
DATE											
VR A15 (4) 20M 1/65 BP											



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
CERTIFICATE OF DEATH														
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)										
a. COUNTY <b>Somerset</b>				a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>										
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>				c. LENGTH OF STAY IN 1b <b>Lifetime</b>										
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Sackertown Rd.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
3. NAME OF DECEASED (Type or print)			First <b>CLARENCE</b>	Middle <b>COCHRANE</b>	Last <b>RIGGIN</b>	4. DATE OF DEATH <b>April 23,</b>	Month <b>1966</b>	Day <b>19</b>	Year <b>1</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 23, 1891</b>	9. AGE (in years last birthday) <b>74 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>	13. FATHER'S NAME <b>D. Qui nn Riggan</b>	14. MOTHER'S MAIDEN NAME <b>Mariah Sterling</b>	15. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dealer</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Retail Seafood</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Crisfield, Md.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-14-9676</b>		17. INFORMANT <b>Mrs. Mildred W. Riggan, Same as 2, abov</b>		Address								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]														
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b> INTERVAL BETWEEN ONSET AND DEATH <b>24 hr.</b>														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>5271</b> (b) <b>Right Side Heart Failure</b> 3 yrs.														
DUE TO (c) <b>Emphysema: Severe</b>														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)												
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)								
21. I certify that (I) (this hospital) attended the deceased from <b>July 1963</b> to <b>4/22 1966</b> , that (I) (we) last saw the deceased alive on <b>4/22 1966</b> and that death occurred at <b>3:30 AM</b> , from the causes and on the date stated above.														
22a. SIGNATURE <i>Robert E Roberts</i>														
22b. DATE SIGNED <b>4/23/66</b>														
22c. PHYSICIAN'S NAME (Type) <b>Robert E. Roberts, M.D.</b>		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS <b>Crisfield, Md.</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Apr. 26, 1966</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>Sunnyridge Cemetery</b>		23d. LOCATION (City, town or county) <b>Crisfield, Md.</b>				(State)				
24. FUNERAL DIRECTOR <b>Bradshaw &amp; Sons-- Crisfield, Md.</b>		ADDRESS		25a. REC'D BY REGISTRAR <b>APR 28 1966</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>								



1 M

FOR STATE  
HEALTH DEPT.MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05946

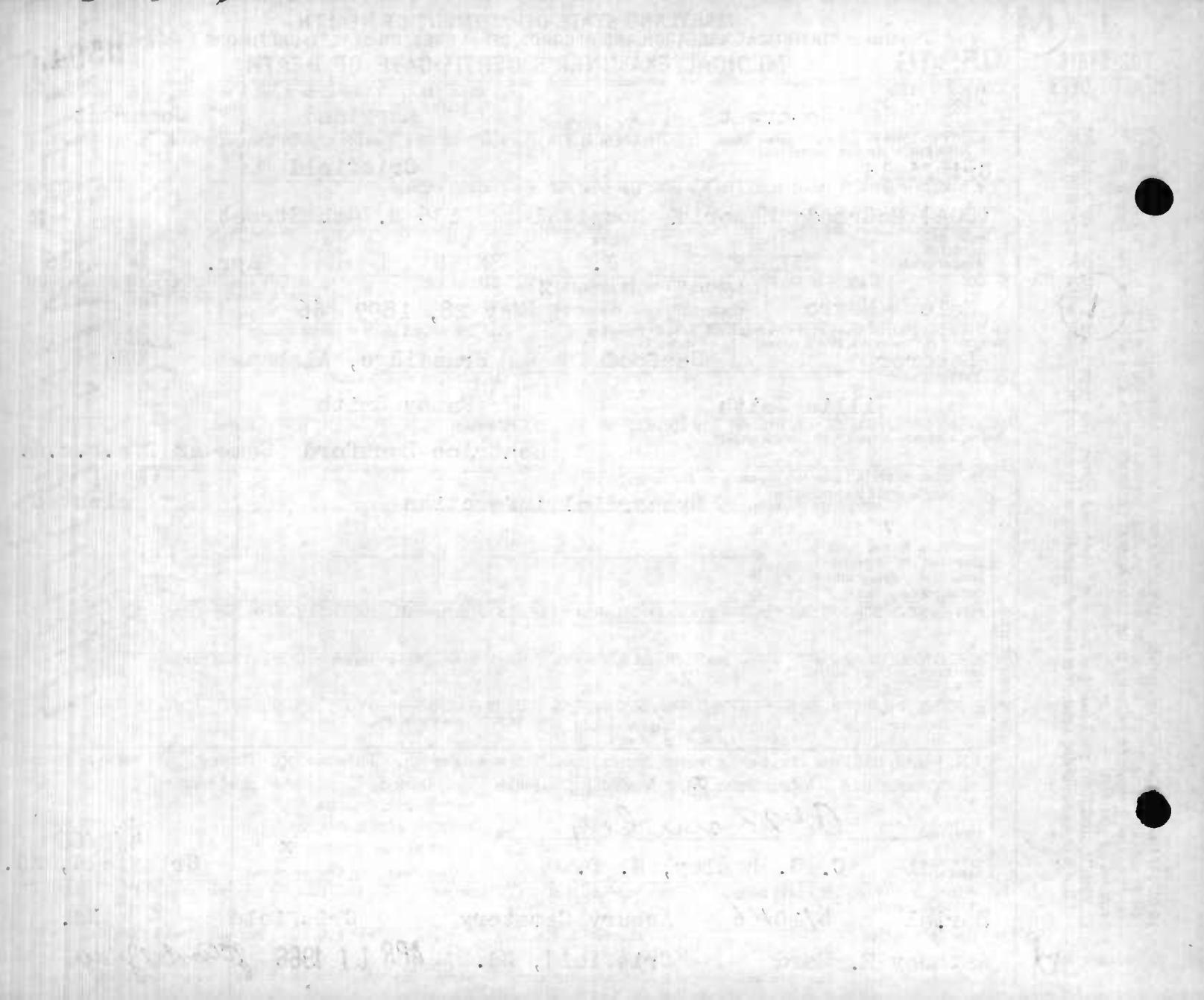
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05946

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)	
Somerset MARYLAND		b. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Crisfield		Crisfield 19 - 1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) (DOA) McCready Memorial Hospital		d. STREET ADDRESS 136 S. 4th Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED First WILLIE Middle J. Last SMITH		4. DATE OF DEATH Apr. 4 1966	
5. SEX Male Negro 6. COLOR OR RACE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 28, 1899 9. AGE (In years last birthday) 66 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Seafood	
11. BIRTHPLACE (State or foreign country) Brundidge, Alabama		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Willie Smith		14. MOTHER'S MAIDEN NAME Fanny Smith	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 17. INFORMANT Address	
		Beatrice Lankford Same as 2 a.b.c.d.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 4201 INTERVAL BETWEEN ONSET AND DEATH minutes			
DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			
20e. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>C. G. Rawley</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) C. G. Rawley, M. D.		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county) Crisfield, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/10/66 23c. NAME OF CEMETERY OR CREMATORIAL Asbury Cemetery	
23d. LOCATION (City, town or county) (State) Crisfield Md.			
24. FUNERAL DIRECTOR Anthony E. Ward		ADDRESS Crisfield, Md.	
25a. REC'D BY REGISTRAR APR 11 1966		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



1 M

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05947

CERTIFICATE OF DEATH

05944

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1.		PLACE OF DEATH a. COUNTY <b>Somerset</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Somerset</b>		
		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>		c. LENGTH OF STAY IN 1b <b>Lifetime</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>		d. STREET ADDRESS <b>Jacksonville Rd.</b>		
		d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Jacksonville Rd.</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First <b>OTIS</b>	Middle <b>CLINTON</b>	Last <b>WARD</b>	4. DATE OF DEATH Month <b>April</b>	Day <b>11</b>	Year <b>1966</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 16, 1917</b>	9. AGE (In years last birthday) <b>49 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retail Dealer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Seafood</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Crisfield, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13. FATHER'S NAME <b>Murray E. Ward</b>		14. MOTHER'S MAIDEN NAME <b>Blanche O. Ward</b>								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT		Address				
				<b>Mrs. Lorraine Ward-Jacksonville Rd.-Crisfield, Md.</b>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH <b>3 days known to events</b>								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>151X</b>		<b>Toxic Megacarditis + Uremia</b>								
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) <b>Congestive heart failure</b>		OUE TO <b>Causes</b>	<b>Carcinoma of stomach + Metastasis</b>							
(c) <b>Bronchitis - 6 year</b>		OUE TO <b>Causes</b>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Bronchitis - 6 year</b>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>While at work</b>		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>Feb. 16, 1966</b> , to <b>April 11, 1966</b> , that (I) (we) last saw the deceased alive on <b>April 8, 1966</b> , and that death occurred at <b>62</b> M, from the causes and on the date stated above.		22b. DATE SIGNED <b>4/12/66</b>								
22a. SIGNATURE <b>A. N. Barr</b>		M.O. ATTENDING PHYS. <b>X</b>		M.O. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>				
22c. PHYSICIAN'S NAME (Type) <b>A. N. Barr, M.D.</b>		22d. ADDRESS <b>Crisfield, Md.</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Apr. 13, 1966</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>Sunnyridge Cemetery</b>		23d. LOCATION (City, town or county) <b>Crisfield, Md.</b>		(State)		
24. FUNERAL DIRECTOR <b>Bradshaw &amp; Sons-- Crisfield, Md.</b>		ADDRESS		25a. REC'D BY REGISTRAR <b>APR 18 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE		

Wind. 30 27 22 20 18

X

metres

225 31 29

1 M  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05945

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 1c. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Item 3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Somerset</b>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Princess Anne</b>		b. COUNTY <b>Somerset</b>	
c. LENGTH OF STAY IN 1b <b>Life time</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Princess Anne</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Joseph</b>		First <b>R</b>	Middle <b>Waters</b>
4. DATE OF DEATH <b>4-14-66</b>		Month <b>4</b>	Day <b>14</b>
5. SEX <b>male</b>	6. COLOR OR RACE <b>col</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-15-91</b>
9. AGE (In years last birthday) <b>74</b> yrs.	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Tailer</b>	
11. BIRTHPLACE (State or foreign country) <b>Princess Anne, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Alford Waters</b>		14. MOTHER'S MAIDEN NAME <b>Rosa Banks</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b>			
4201 DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)			
DUE TO			
(c)			
INTERVAL BETWEEN ONSET AND DEATH minutes			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Everett Sutter</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Everett Sutter MD</b>		DATE SIGNED <b>4-18-66</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-18-66</b>	
22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>John Wesley</b>		22d. LOCATION (City, town, or county) (State) <b>Princess Anne, Md.</b>	
23. FUNERAL DIRECTOR <b>William H James Jr Princess Anne, Md.</b>		24a. REC'D BY REGISTRAR <b>APR 20 1966</b>	
		24b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

desperately  
and secondly  
will still

stationary  
possibly

for him to stay  
in the same

area specially  
when he  
comes back

and the  
no doubt, probably

*81* *R* *M*  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

**CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY Somerset		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Somerset	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crisfield		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crisfield		d. STREET ADDRESS 112 Locust St.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Edw. W. McCready Memorial Hosp.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First JOHN	Middle E.	Last Wilson	4. DATE OF DEATH	Month April	Day 8	Year 1966
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 7, 1901	9. AGE (in years last birthday) 65 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance		10b. KIND OF BUSINESS OR INDUSTRY City of Crisfield		11. BIRTHPLACE (County & State, or foreign country) Somerset - Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harry Wilson		14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Helen Wilson, Crisfield, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> <i>33IX</i> Conditions, If any, which gave rise to immediate (b) _____ cause (a), stating the (c) _____ underlying cause last. DUE TO DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 8, 1966, and saw the deceased alive on April 8, 1966, and that death occurred at 5:20 P.M., from the causes and on the date stated above.		22b. DATE SIGNED					
22a. SIGNATURE <i>R.E. Roberts</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
22c. PHYSICIAN'S NAME (Type) R. E. Roberts, M.D.		22d. ADDRESS Crisfield, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Apr. 11, 1966		23c. NAME OF CEMETERY OR CREMATORIUM Crisfield Cemetery		23d. LOCATION (City, town or county) Crisfield, Md. (State)	
24. FUNERAL DIRECTOR Bradshaw & Sons — Crisfield, Md.		ADDRESS					
				25a. REC'D BY REGISTRAR APR 14 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

